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4c. Family Planning Services (same for categorically and medically needy clients, but limited to clients of child-bearing age).

Family planning services are any medically approved means, including diagnostic evaluation, drugs, supplies, devices, and related counseling for the purpose of voluntarily preventing or delaying pregnancy. These services can be furnished under the supervision of a physician or dispensed by a pharmacy. Services to be provided to individuals of child-bearing age, including minors who may be sexually active, to voluntarily choose not to risk initial pregnancy or to limit the number and spacing of their children.

Covered services include an office call for a complete exam, drugs, supplies, and devices when such services are provided by or under the supervision of a medical doctor, osteopath, or other eligible family planning provider. Family planning supplies not furnished by the provider as part of the medical services must be prescribed by a physician and purchased at a pharmacy. An exception is condoms and similar supplies which do not require a prescription.

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5. PHYSICIANS' SERVICES (same for categorically needy and medically needy clients).

Physicians' services are defined as services provided with the scope of his/her profession by a doctor of medicine or osteopathy licensed under State law where the services are performed:

No payment will be made for services of staff in residence (e.g., interns and residents) or medical staff functioning in an administrative capacity for a hospital, nursing home, or medical care facility, including physician-owners. In relation to outpatient services, physicians' fees for covered services are payable only when such payment does not duplicate payment to the facility.

Physicians' services are covered whether furnished in the office, a patient's home, a hospital, a nursing facility or elsewhere, except that:

a) Services must be related to either:

1) a diagnosed mental or physical health condition calling for therapeutic management; or

2) an examination to diagnose a mental deficiency or retardation; or

3) family planning;

b) Physician visits in the nursing home setting are limited to one visit per patient per month; additional visits must be documented as medically necessary;

c) Speech and/or language evaluations by a physician are limited to not more than two in a 12 month period unless documented as medically necessary;

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d) Inpatient services related to a diagnosed mental health condition are covered only when rendered by a psychiatrist or physician (M.D. or D.O.), or psychological testing by a licensed psychologist under the direction of psychiatrist or physician (M.D. or D.O.); and

e) The following specific items are excluded:

1) routine physician examinations not medically necessary for diagnosis or treatment of an illness, injury, or for the prevention of disability with the following exceptions:

a. screening and preventive services are covered under the EPSDT program for children under the age of 21. See item 4B under this attachment;

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b. screening mammograms for women are covered with limitations;

c. one preventive medicine visit per year may be covered for any recipient;

d. recommended preventive immunizations are covered.

f) Certain selected surgeries, as specified by the MA program, that may be performed on an outpatient basis, are not covered when performed on an inpatient hospital basis unless there are medical factors that contraindicate the performance of the procedures on an outpatient basis.

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g. Laboratory services performed in the physician's office are limited to those determined to be reasonable and appropriate for that site, and to a payment amount determined to be adequate to cover those procedures. Other laboratory services are covered upon determination by the department to be medically necessary for the setting and specific patient.

/01/94 h. Physical therapy services as defined in 1.a. of this attachment.

6. MEDICAL CARE FURNISHED BY PRACTITIONERS WITHIN SCOPE OF THEIR PRACTICE AS DEFINED BY STATE LAW

No payment will be made for services of staff in residence or medical staff functioning in an administrative capacity for a hospital or nursing care facility , including practitioner-owners. In relation to outpatient services, practitioner fees for covered services are payable only when such payment does not duplicate payment to the facility.

a. Podiatrists' Services: Covered services include those within the scope of practice under state law, and limited by the department, necessary to diagnose and treat illness, injury, prevention of disability, or provided to individuals under the age of 21 as part of the EPSDT program. Routine foot care services are excluded except when provided to recipients suffering from specific systemic diseases for which self-treatment would be hazardous.

b. Optometrists' Services:

Covered services include:

1) Complete eye examination if medically necessary. Examinations which exceed a frequency of once every two years must be documented as medically necessary.

2) The following corrective lenses; some of which require prior authorization:

a) single-vision or multi-focal eyeglasses;
b) cataract lenses;
c) contact lenses, evaluations and services;
d) special lenses, as specified by the department.

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3) Orthoptic and low vision evaluations, services and aids (which must be prior authorized).

Requirements relative to the provision of eyeglasses are described in item 12.d. of this attachment.

c. **Chiropractors" Services:**

Chiropractic x-rays, as limited by the department, are covered for all age groups. Chiropractic spinal manipulations are covered for all age groups.

d. **Other Practitioners' Services**

Oral Surgeons (same for categorically and medically needy clients.)

Services provided within the scope of his profession, as defined by State Law, by a licensed oral surgeon are covered as follows:

1. for hospital inpatients under the conditions specified in item 1.c;

2. for treatment provided on a hospital outpatient basis or in the office for treatment of conditions specified in item 1.c.1)a.).

Certified Nurse Anesthetists (CRNAs)

Services provided within the scope of their profession are covered for registered nurses certified by the Council on Certification of Nurse Anesthetists or recertified by the Council on Recertification of Nurse Anesthetists. Services are limited to those provided on an inpatient or outpatient basis and reimbursement is directed through the employing or contracting hospital.

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Certified Pediatric and Family Nurse Practitioners

Services provided by certified family or pediatric nurse practitioners will be covered to the extent the service is covered when provided by an MD, DO, or DPM. The certified family or pediatric nurse practitioner can be separately enrolled and assigned a unique provider ID number to bill and be reimbursed directly or services can be provided as physicians' services and billed by the employing physician.

To be eligible for separate reimbursement, the nurse practitioner must be licensed to practice as a registered nurse, certified by the state licensing authority as a nurse practitioner, and certified as a pediatric nurse practitioner by the American Nurses'Association or the National Board of Pediatric Nurse Practitioners, or certified as a family nurse practitioner by the American Nurses'Association. Services must be provided in collaboration with a physician (MD, DO, DPM) pursuant to the written provisions of a current collaborative practice agreement which is mutually agreed to by both professionals. The physician must provide delegation/supervision as appropriate.

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7. **HOME HEALTH CARE SERVICES** (Same for categorically needy and medically needy clients)

a. **Covered Services**

The services and items listed below are covered when provided to a recipient in his/her place of residence by a certified home health agency and ordered by the recipient's physician as part of a comprehensive written plan of care which is reviewed by the physician at least every 60 days.

1) Intermittent or part-time nursing services furnished by a Medicare-certified home health agency. In areas where no home health agency exists, nursing services may be covered when provided by a registered nurse who:

- is licensed to practice in Michigan;
- receives written orders from the patient's physician;
- documents the services provided; and
- has received instructions in acceptable clinical and administrative record keeping from a public health department nurse.

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Nursing services may be provided on a per visit or an hourly basis. Hourly services will be covered only for persons with severe disabilities, complex care needs or catastrophic illnesses when:

- the total health care for the patient is provided according to a comprehensive plan of care which has been prior authorized by the single state agency;

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- the total Medicaid cost of the services under the care plan does not exceed the total Medicaid costs of the appropriate institutional alternative, as determined by the single state agency;

- the care plan is implemented under the supervision of a case manager approved by the single state agency and not associated with a home health service provider; and

- the services of the home health agency are determined to be essential to the maintenance of or the movement toward, independent living or care in the most appropriate non-institutional setting.

2) Medical Supplies, Durable Medical Equipment and Oxygen

   a) Medical supplies, equipment and appliances for use in patient's place of residence.

      1) Coverages include: Hypodermic syringes/needles, ostomy supplies, dressings necessary for the medical management of the patients, etc.

      2) Certain items require prior authorization.

      3) For persons in medical institutions including nursing care facilities, most medical supplies are included in the rate paid to the facility.

      4) Exclusion: Incidental first-aid supplies (e.g., adhesive bandages).

      5) Freedom of choice of providers is waived in authority with 1915(a) for diapers and selected incontinence supplies (medical devices) in acceptance of certification that adequate services and devices will be provided. Diapers and selected incontinence supplies must be obtained from the State's contractor.

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b) Durable medical equipment (DME) is a benefit for recipients under age 21 if they are not confined to a long term care facility. DME for a recipient in a long term care facility is considered included in the facility's per diem rate. However, if the DME is customized for the recipient's own full-time use, it is not considered included in the per diem rate and is separately reimbursable to an appropriately enrolled provider.

DME is a benefit for recipients age 21 or older under the following conditions:

1) When the recipient is in a long term care facility, DME is covered only if it is customized for the recipient's full-time use. It is separately reimbursable to an appropriately enrolled medical supplier. The medical supplier is responsible for requesting prior authorization.

2) When a recipient is enrolled in Medicare Part B, and Medicare has made payment on the equipment, Medicaid may cover the coinsurance and/or deductible amounts, as described in 3.2A.

3) When the equipment is needed to prevent frequent hospitalization or institutionalization, is life sustaining, or replaces a malfunctioning body member, Medicaid may cover the equipment.

Prior authorization of DME is required for recipients of all ages, except where exempted for selected diagnostic codes, and for equipment that is considered includes in a long term facility's per diem rate.

The Program determines if the equipment is to be rented or purchased. Such determination includes consideration of cost versus benefit.

c) Oxygen is covered for the recipient residing in his/her home or in a long term care facility when medically necessary and when ordered by a physician.

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3) Home health aide services, provided on a per visit, or in the case of severe disabilities, complex care needs or catastrophic illness delineated in 1) above, on an hourly basis.

4) Physical therapy as described in 1.a.

5) Occupational therapy services of a restorative nature, ordered in writing by a physician, are covered. Therapy services must be performed by a registered occupational therapist, or a certified occupational therapy assistant under the supervision of occupational therapist. Occupational therapy services are covered for persons qualifying for the Children's Special Health Care Services, or if part of the care plan for persons with severe disabilities, complex care needs or catastrophic illness. Services require prior authorization.

6) Speech therapy must be restorative and ordered by a physician, in writing. Services must be rendered by audiologists who have a Certification of Clinical Competency. speech therapy must be part of the care plan for persons with severe disabilities, complex care needs or catastrophic illness. Services require prior authorization.